

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 006205	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/10/2014
NAME OF PROVIDER OR SUPPLIER SOUTHERN INDIANA REHABILITATION HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 3104 BLACKISTON BLVD NEW ALBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one (1) State complaint.</p> <p>Date of survey: 06-10-14</p> <p>Facility number: 006205</p> <p>Complaint number: IN00144561</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Southern Indiana Rehabilitation Hospital is in compliance with 410 IAC 15-1.5-1, Dietetic services and 410 IAC 15-1.5-6, Nursing services, Hospital Licensure Rules.</p> <p>QA: cloughlin 06/20/14</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE